



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Shannon Medical Center

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-17-0774-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare would have reimbursed the provider at the base APC rate of \$1,336.89 for APC # 0022. Allowing this at 200% would yield a fair and reasonable allowance of \$2,673.78. Based on your payment of \$1,608.24 for the APC a supplemental payment is still due of \$1,065.54 the APC alone, at this time."

Amount in Dispute: \$1,065.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined additional monies are owed in the amount of \$892.21. Interest in the amount of \$25.84 has been issued."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2016	20525	\$1,065.54	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What amount was paid by the carrier?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for \$1,065.54 for outpatient hospital services rendered on January 21, 2016.

The respondent indicates in pertinent part “Respondent issued payments to Petitioner in the amount of \$172.63 on April 25, 2016 (Check No. 0127444726) and \$1,608.24 on November 1, 2016 (Check No. 0132178121). Pursuant to the newly submitted CPT code 20525, Respondent is in the process of issuing an additional payment of \$892.91 pursuant to the Texas Workers’ Compensation Fee Schedule.”

Evidence presented supports the payment of \$2,673.78. This amount will be considered in review of the services in dispute found below.

2. The services in dispute are outpatient hospital services and are subject to provisions of 28 Texas Administrative Code §134.403. The relevant portions are found below:

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPS are found below:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysfctsh.pdf,

- *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPTS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPTS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPTS Addenda, Addendum, D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPTS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Review of the submitted medical claim finds no request for separate reimbursement of implantables. The services in dispute are reimbursed per the fee calculations below:

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.8324	40% non-labor related	Payment	Maximum allowable reimbursement
20525	T	5074	\$1,414.28	\$1,412.28 x 60% = \$848.57	\$848.57 x 0.8324 = \$706.35	\$1,414.28 x 40% = \$565.71	\$706.35 + \$565.71 = \$1,272.06	\$1,272.06 x 200% = \$2,544.12
							Total	\$2,544.12

3. The total allowable reimbursement for the services in dispute is \$2,544.12. The amount previously paid by the insurance carrier is \$2,673.78. No additional payment recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 5, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.